ACTIVE EMPLOYEE

State Health Benefit Plan
Decision Guide

for January 1, 2006 – December 31, 2006

Georgia Department of Community Health

OPEN ENROLLMENT
Oct. 17 – Nov. 8, 2005

Important Information
Please Read

PHONE NUMBERS/CONTACT INFORMATION

State Health Benefit Plan (SHBP) : **www.dch.georgia.gov**

PPO, PPO CCO, Indemnity:

Member Services	877-246-4189 TDD 800-545-6751 www.myuhc.com/groups/gdch
Pharmacy Information (ESI)	877-650-9342 TDD 800-842-5754

HDHP:

Member Services and Pharmacy	877-246-4195

HMOs:

BlueChoice	800-464-1367 TDD 404-842-8073	www.bcbsga.com
Cigna	800-564-7642	www.cigna.com
Kaiser Permanente	800-611-1811 TDD 800-255-0056	www.kaiserpermanente.org
United Healthcare	866-527-9599 TDD 800-955-8770	www.myuhc.com
TRICARE Supplement:	800-638-2610 ext. 255	www.asitrisuppga.com
All Options: Eligibility	404-656-6322 or 800-610-1863	

Pages 3 through 6 of this Guide contain Plan changes effective January 1, 2006. Prior to the start of the 2006 Plan Year, the Plan will post a new Summary Plan Description (SPD) for each Plan Option to the DCH Web site, **www.dch.georgia.gov**. This SPD is your official notification of Plan Changes effective January 1, 2006. You may print or request a paper copy from your personnel/payroll office. Please keep your Summary Plan Description (SPD) for future reference. If you are disabled and need this information in an alternative format, call the TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 38342, Atlanta, GA 30334.

Photos on the cover courtesy of the Georgia Department of Economic Development.

ACTIVE EMPLOYEE RESPONSIBILITIES

This booklet contains a brief explanation of each Plan Option, What's Changing for the new Plan Year, January 1 – December 31, 2006, and a benefits comparison chart. A full *Decision Guide for Active Employees,* which contains additional information, can be found at **www.dch.georgia.gov**.

- Read the current *Decision Guide, SPD* and *Updaters* to understand your Health Plan Options and changes in benefits prior to making your Open Enrollment elections.
- Access the Open Enrollment Web site to make Open Enrollment elections and answer the surcharge questions. **Print the confirmation notice displaying the elections you made and verify the elections shown are correct prior to the close of Open Enrollment.**
- Contact your employer or payroll location Benefit Coordinator for assistance if you experience difficulties.
- You will automatically be charged the surcharge if you fail to answer all questions concerning the surcharges. The surcharges(s) will apply for the 2006 plan year unless you experience a qualifying event.
- Eligibility verification documents for all dependents for whom coverage has been requested should be submitted within the required time frame.
- A new SHBP member should provide a Certificate of Creditable Coverage from prior health insurance to reduce or eliminate any pre-existing condition limitation for the PPO or Indemnity Options.

Notify the Plan of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Call 1-877-878-3360 or 404-260-9514.

! PLEASE READ IF YOU WILL BE RETIRING DURING THIS PLAN YEAR!

If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage, starting in 2006. Please see pages 20–24 for more details.

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ONLINE ENROLLMENT/CHANGES

This year all employees must make their health benefit selection on-line at www.shbp.org. The Open Enrollment dates are October 17 – November 8, 2005 and the Web site will be available beginning 12:01 a.m. October 17 and will close at 4:00 p.m. on November 8, 2005.

After the close of the Open Enrollment Period, no changes in coverage option or tier will be allowed unless you experience a qualifying event. SHBP complies with the Internal Revenue Code, Section 125, which mandates requirements for cafeteria programs offering pre-tax premiums.

How to Make Your Online Enrollment/ Changes

1 Go to **www.shbp.org** and login. You will use your Policy number which is your Social Security number and birth date to log in. Please contact your payroll location Benefit Coordinator if you have trouble with the login process.

2 Once you have signed on, your 2005 benefit information and enrolled dependents will appear. Please review to make sure this information is correct and make any corrections to the basic data, i.e. address.

3 Review your current health insurance option and make any desired changes. You may change your options as many times as you wish during Open Enrollment.

4 Prior to printing a copy of the confirmation notice – review the following: (a) Did you answer the surcharge questions? (b) Are the answers to the surcharge questions correct? (c) Is your benefit selection correct? If any of this information is not correct, go back into the Web site prior to the close of Open Enrollment and make your corrections.

5 Print your confirmation notice. **Verify that all information is correct and keep a copy for your records.** The confirmation statement with the latest date prior to the close of Open Enrollment confirms your benefit selection for the 2006 Plan Year.

How to Remove Surcharges

Tobacco Surcharge

- You must attend a tobacco cessation program sponsored by Kaiser or the American Cancer Society. Additional programs may be approved in the future. Please check the DCH Web site for any updates, **www.dch.georgia.gov**.
- You will receive an attendance certification form. You and the representative should both sign this form.
- You should complete the appropriate Tobacco Affidavit Form available from SHBP at **www.dch.georgia.gov**.
- Give both forms to your employer's Benefit Coordinator to complete the required deduction information.

The change in premiums will be effective based on the payroll schedule of your employer. No refund in premium will be made for previous health deductions that included the surcharge amounts. IRS rules do not allow premium changes to be made retroactively.

Spousal Surcharge

If your spouse becomes covered by his/her employer's health benefit plan, the surcharge can be removed if you make the request and provide proof within 31 days of the effective date of the other coverage.

SHBP PLAN CHANGES EFFECTIVE JANUARY 1, 2006

New UnitedHealthcare (UHC) PPO

The new PPO will be administered by UnitedHealthcare (UHC) effective January 1, 2006. There are some key advantages of the UHC PPO that will benefit you and your dependents. Following is a list of the program enhancements available to you through the UHC PPO. For any changes to the Summary of Benefits, please be sure to review the chart on pages 10 thru 17.

- **National PPO Provider Network with Strong Statewide Coverage**

  UHC's national PPO network includes over 470,000 physicians and other health care professionals, and 4,500 hospitals across 50 states. Currently in Georgia, UHC has over 10,000 physicians and 133 hospitals under contract. While they currently have a strong statewide PPO network, they are aggressively pursuing contracts with providers who are not in their network. Any provider interested in becoming a part of the network should contact UHC directly. Because UHC provides a national network, you will no longer have to pay a higher coinsurance when using providers outside of Georgia. With UHC's PPO program, you receive the same network level of benefits whether you use contracted providers in Georgia or anywhere else in the United States.

- **Commitment to Your Total Health and Well-being**

  UHC is committed to helping you improve your total health and well-being. Through their UnitedHealth Wellness℠ program, they offer both on-site and online wellness programs and services. The UnitedHealth Wellness program is available through **unitedhealthwellness.com** and will provide you and your family access to discounted programs and services to improve your health, save money and keep your life in balance. Some of the features of UnitedHealth Wellness include:

  myRenewell®℠ helps you find health and wellness services and discounts on products and programs.

  UnitedHealth Allies®℠ provides savings of up to 50 percent on certain health care products and services that are not covered by your medical, dental or vision plan.

  Health Assessment an online, confidential survey helps assess your overall current status of health.

  Online Health Improvement Programs let you choose from a variety of six-week programs like losing weight, gaining energy or improving overall health.

  Online Personal Health Manager lets you manage your health information all in one place!

  In addition to these online and self-service wellness tools, UHC also provides 24 hour access to experienced registered nurses through their toll-free NurseLine feature. Nurses are always available to answer your questions and clarify important medical decisions – you can even contact them through their convenient online nurse chat function available on the United member Web site.

Through the Care Coordination program, UHC will assist you with coordinating your hospitalizations, disease management needs and chronic health care issues. UHC provides confidential support for your behavioral health needs through the United Behavioral Health program.

- **Comprehensive Member Service Support**

  UHC understands your concerns with a change in health care providers and will provide experienced member services support during Open Enrollment and after to answer important questions about network access, benefits and transition of care. If you or a family member need continued care with a non-participating provider after January 1, a transition of care application is available and can be requested through Member Services. The transition of care benefit allows you to receive network benefits while transitioning your care from a non-participating provider to a contracted physician in the UHC PPO network. Examples of eligible transition of care patients are a pregnant member in their third trimester, a member with complex and chronic medical needs and patients hospitalized during the transition to UHC.

  In addition to the toll-free member services number, UHC provides a comprehensive Web site, **myuhc.com**. Through this member Web site, you will have online access to benefits information, your eligibility and medical claims history and be able to search the directories of physicians and other health care professionals by location, specialty and language. You can also order replacement ID cards as well as print a temporary ID card. In addition, the site allows participants to search a wide variety of health care topics and participate in live health forums.

Points to Know About the Transition to United Healthcare (UHC)

- Members will receive a new PPO or Indemnity ID card that includes the UHC logo and address. Be sure to show the card to your physician or hospital so that they will know how to submit your claim. You will receive your ID cards through the mail.
- Express Scripts will remain the Pharmacy Benefit Manager for the PPO and Indemnity Plan Options. You will receive a separate pharmacy ID card from Express Scripts through the mail.
- If you file a paper medical claim for services on or before December 31, 2005, the claim must be received by Blue Cross Blue Shield of Georgia (BCBSGA) at P.O. Box 38151, Atlanta, GA 30334, no later than March 31, 2006. This requirement also applies to any claim adjustments. Claims received by BCBSGA after March 31, 2006 will not be paid if the services were received in the year 2005.

Paper claims for services received after January 1, 2006 are subject to the normal 12-month timely filing requirement and should be filed with UHC.

New Tool Assists You in Making Your Open Enrollment Selection

Choosing the right health plan is an important decision and the SHBP is providing a Plan Cost Estimator (PCE) tool to assist you. The PCE offers you a simple way to help determine which option is best for you and your family. This online tool lets you compare how your out-of-pocket expenses may vary under the different health plan options available to you.

You can use the PCE to review cost information for prescriptions, anticipated tests and procedures and, if offered, determine how much to contribute to your Flexible Spending Account (FSA). The information provided by PCE is not meant to be an endorsement of any particular health plan. The service is offered only to help you compare your estimated expenses across each health plan option.

Access the link to the PCE tool at the DCH Web site **www.dch.georgia.gov** and click on the Find Information about Open Enrollment under "How Do I?"

HMO Live or Work Rule

Effective January 1, 2006, the live or work rule will no longer be based on the county in which you live or work to obtain HMO coverage. You and your eligible dependents may join an HMO of your choice if the HMO is offered in your area or surrounding counties. You will need to contact the particular HMO of interest directly to determine if that HMO is offered in your area. **Out-of-State Coverage: If you are living outside the state of Georgia you may not have all options available to you.** You will need to inquire with the HMO if services are available in your area before making your selection.

! VERY IMPORTANT: DEPENDENTS MUST BE VERIFIED PRIOR TO THEIR COVERAGE EXPIRATION DATE

Continued Coverage for Students, Disabled Children and Legal Children

- **Recertification must be received before coverage expiration date.**
- **The dependent will not be eligible after the expiration date, if the documentation is not received before their coverage expires. You may add the dependent during the next Open Enrollment period.**

Additional information can be found at www.dch.georgia.gov.

High Deductible Health Plan

A High Deductible Health Plan (HDHP) will be offered to all employees effective January 1, 2006. This Option offers you a new way to manage your healthcare dollars. When you enroll:

- Your monthly insurance premiums are lower.
- You may qualify to start a Health Savings Account (HSA) for yourself, through a bank or other financial organization acting as an HSA custodian/administrator, and set aside tax-free dollars to pay for eligible healthcare expenses now or in the future. HSAs typically earn interest and may even offer investment options.

You may start an HSA when you enroll in the HDHP as long as you do not have other medical coverage. You will be responsible for selecting your HSA vendor, setting up your account, and making contributions.

See page 18 for more detail on the new HDHP and the opportunity it provides to enroll in a Health Savings Account.

See the Benefits Comparison that starts on page 10 for more about how the Plan covers specific expenses.

In return for the lower premiums and the potential tax advantages of a Health Savings Account, you take on more responsibility for your healthcare needs when you enroll in the HDHP. You:

- Have a higher deductible, with benefits payable only after you meet the deductible (except for preventive care coverage)
- Pay coinsurance after you have satisfied the deductible rather than set dollar co-payments for network office visits and prescription drugs.
- Another tax savings option you may want to consider is a Health Care Spending Account (HCSA), if it is offered through your employer's cafeteria program. A HCSA helps you save tax dollars, approximately 26-45%, depending on your tax situation. By electing to use a HCSA, you may set aside up to $5,040 annually to cover health-related treatment expenses for yourself and your dependents. If you contribute to a HCSA, it is your responsibility to make sure your contributions do not violate any HSA rules.

State Health Benefit Plan Medicare Policy

Federal Law requires SHBP to pay primary benefits for active employees and their dependents as long as active employment continues. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty.

You must enroll for coverage for you and any eligible dependents during the Open Enrollment period prior to your retirement if you want to have health insurance under SHBP when you retire, (if you are not already enrolled). Members who are enrolled in Medicare due to End Stage Renal Disease (ESRD) will need to contact the Social Security Administration to determine when Medicare becomes primary.

Once retired, during the annual Retiree Option Change Period, you are allowed to change your Plan option only. You may add dependents only if you experience a qualifying event, request the change within 31 days and provide documentation required by SHBP.

UNDERSTANDING YOUR PLAN OPTIONS

To maximize your health benefits, it is important to fully understand how each of the SHBP options works. This brief overview will help you determine which option best fits your health care needs. **Keep in mind that failure to use network providers could result in a financial impact to you.**

PPO Options

The PPO Options offer you a network of more than 10,000 Georgia participating physicians and 133 Georgia hospitals.

You also have the added benefit of access to a national network of participating providers and hospitals across the United States.

In order to receive the highest level of benefit coverage and avoid filing claims and balance billing, you will need to use an in-network provider. If you choose to use an out-of-network provider, the reimbursement will be at a lower level of benefit coverage.

A PPO CCO is also available. See page 8 for more details.

To view the list of PPO providers, visit **www.myuhc.com/groups/gdch**, or call 1-877-246-4189.

! It is ultimately your responsibility to verify that a provider is in the PPO or HMO network prior to receiving services. Providers may enter or leave the network at any time.

HMO Options

HMO Options are available to SHBP-eligible employees who live or work in the county or surrounding counties in which an HMO is offered.

HMOs provide 100 percent benefit coverage for preventive health care needs after paying applicable co-payments. There are no bills or claim forms. Certain services are subject to a deductible and co-insurance amount (i.e., inpatient and outpatient hospital facility, inpatient professional charges, etc.). These deductibles and co-insurance amounts have an annual out-of pocket maximum. When you meet this maximum, the HMO pays your covered services at 100 percent. **Co-payment amounts are excluded from the annual out-of-pocket maximum.**

In HMOs, you are responsible for selecting a Primary Care Physician (PCP) from a list of participating providers (see note). You must be referred to a network provider by your participating physician or facility for your expenses to be covered, except in emergencies and in other limited cases. If you receive care from a provider other than your PCP, or without your PCP's referral, there is no coverage even if the physician or facility is in the HMO network.

An HMO CCO is also available. See page 8 for more details.

! NOTE: UnitedHealthcare HMO does not require you to select a PCP or obtain referrals to see specialists.

! Diagnostic testing and lab services performed at independent radiology and lab offices located in the Kaiser facilities are subject to deductible and co-insurance.

PPO, HMO and High Deductible Health Plan Consumer Choice Options (CCO)

Selection of any CCO option does not provide enhanced benefits.

The CCO premiums are higher than the corresponding Option. For the increased cost, you can request that a Georgia out-of network provider be reimbursed as an in-network provider. This is referred to as a nomination.

The out-of-network provider must accept the fees and conditions of the network and be approved by the network BEFORE you receive any services from that provider.

This in-network relationship between you and the provider exists only for you and the provider. Other family members who wish to receive in-network benefits from that provider must complete a provider nomination form. You may nominate as many providers as you wish.

SHBP rules do not allow you to change your coverage option if the provider you would like to nominate rejects the nomination.

Only providers located and licensed in Georgia are eligible for nomination.

For further details and to obtain the necessary paperwork, please call the selected plan option member services department.

Indemnity Option

The Indemnity Option is a traditional fee-for-service plan that generally provides the same benefit coverage level no matter which qualified medical provider you use. The Plan reimburses up to the Plan's allowed amounts for covered services. The Indemnity Option also uses contracted healthcare providers who have agreed to discounted rates without balance billing for charges over the allowed amount. As long as you see a participating provider, you may not be balance billed for covered services. However, not all providers participate in these special arrangements. In most instances, non-participating providers' billed charges are considerably higher than the Plan's allowed amounts.

The SHBP does not have the legal authority to intervene when non-participating providers balance bill you. As a result, the SHBP cannot reduce or eliminate amounts balance billed. The SHBP cannot make additional payments above the allowed amounts when you are balance billed by non-participating providers.

TRICARE Supplement for Eligible Military Members

The TRICARE Supplemental Insurance is offered to employees and dependents who are eligible for TRICARE and who have a Defense Enrollment Eligibility Reporting System (DEERS) number.*

Considerations

- TRICARE will become your primary insurance.
- TRICARE Supplement will become your secondary coverage.
- TRICARE covers full-time students only to age 23. You must select another SHBP option during the Open Enrollment period prior to your child reaching age 23 to cover a full-time student from age 23 to 26. (Reaching age 23 as a full-time Student is not a qualifying event).
- Tobacco and spousal surcharges do not apply.
- COBRA legislation requires SHBP to offer continuation of coverage when coverage is lost. If you elect COBRA and the premiums are paid, there is NO break in SHBP coverage. If you elect coverage through the Association and Society Insurance Corporation's (ASI) portability feature instead of COBRA, you will no longer be covered by SHBP.

What Happens at Age 65

- When you and/or your spouse are ineligible for Medicare, TRICARE Supplement continues with submission of disallowance by Social Security.
- When you and/or your spouse are entitled to Medicare Part A and enrolled in Medicare Part B, your coverage will continue through TRICARE Supplement.
- When you and/or your spouse are eligible for Medicare, Medicare will be your primary insurance TRICARE for Life – secondary and TRICARE Supplement – Tertiary.
- When you or your spouse are eligible for Medicare, if you wish to cover your spouse through SHBP, you need to select another Option during the Open Enrollment Period prior to you or your spouse reaching age 65.
- Attainment of age 65 and eligibility for Medicare is a qualifying event and will allow you to change to another Plan option.
- When you and/or your spouse reach age 65 and reside overseas, your coverage will continue through the TRICARE Supplement if you are entitled to Medicare Part A and are enrolled in Medicare Part B.

! *TRICARE covers dependents to age 23 even if they are not a full-time student. However, SHBP only covers dependents who are not full-time students to age 19. You should not elect the TRICARE Supplement if you wish to cover a child who is between the ages of 19 and 23 and is not a full-time student.

! If you enroll in TRICARE Supplement and are not eligible, you will be enrolled in the PPO Option which includes the spousal and tobacco surcharges. You will be required to pay the PPO premiums retroactive to your date of ineligibility or your coverage will be terminated effective January 1, 2006.

BENEFITS COMPARISON: PPO, INDEMNITY, HDHP AND HMO OPTIONS

Schedule of Benefits for You and Your Dependents for January 1, 2006–December 31, 2006

Dollar amounts, visit limitations, deductibles and out-of-pocket limits are based on a January 1–December 31, 2006 Plan Year.

NOTE: Coverage is defined as allowed eligible expenses.

	PPO OPTION		INDEMNITY
	In-Network/Georgia	Out-of-Network	
Covered Services	*The Plan Pays:*		*The Plan Pays:*
Maximum Lifetime Benefit (combined for all SHBP Options)	$2 million		$2 million
Pre-Existing Conditions (1st year in Plan only, subject to HIPAA)	$1,000		$1,000
Lifetime Benefit Limit for Treatment of: (combined for PPO Option, Indemnity and HDHP) • Temporomandibular joint dysfunction (TMJ) • Substance abuse	$1,100 3 episodes		$1,100 3 episodes
Deductibles/Co-Payments: • Deductible—individual • Deductible—family maximum	$500 $1,500	$600 $1,800	$500 $1,500
• Hospital deductible per admission	$250		$400
Annual Out-of-Pocket Limits: • Individual • Family	$1,100 $2,200	$2,200 $4,400	$2,200 $4,400
Physicians' Services			
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	100% after a $30 per visit co-payment; not subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive healthcare • Annual gynecological exams (these services are not subject to the deductible)	100% after $30 co-payment per office visit. No co-payment for associated tests and immunizations. Maximum of $500 per person per Plan Year.	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.	90% per office visit after deductible. No deductible for associated lab and test charges, up to a maximum of $200 per person per Plan Year; additional $125 benefit for screening mammogram.
Maternity Care (prenatal, delivery and postpartum)	90% of coverage; not subject to deductible after initial $30 co-payment	60% of coverage; subject to deductible	90% of coverage; subject to deductible

Exclusions and limitations vary among Plan options. Contact your specific Plan option for more information.

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences*
$2 million		$2 million	
None		None	
$1,100 3 episodes		No separate lifetime benefit limit	
$1,100 $2,200	$2,200 $4,400	$200 $400	
Not applicable		Not applicable	
$1,700 $2,900	$3,800 $7,000	$1,000 $2,000	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after a per visit co-payment** of $20 for primary care and $25 for specialty care	** Includes lab and x-rays done in the physician's office.
100% coverage up to a maximum of $500 per person per plan year. Not subject to deductible.	Not covered, charges do not apply to deductible or annual out-of-pocket limits.	100% after a per visit co-payment of $20 for primary care and $25 for specialty care. No co-payment for immunizations and mammograms.	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after initial $25 co-payment	

Chart continued pg. 12

	PPO OPTION		INDEMNITY
	In-Network/Georgia	Out-of-Network	
Physicians' Services	*The Plan Pays:*		*The Plan Pays:*
Physician Services Furnished in a Hospital Surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Physician Services for Emergency Care	90% of coverage; subject to deductible	90% of coverage; subject to in-network deductible	90% of coverage; subject to deductible
Outpatient Surgery— • When billed as office visit	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
• When billed as outpatient surgery at a facility	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Allergy Shots and Serum	100% for shots and serum after $30 per visit co-payment not subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Hospital Services			
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	90% of coverage; subject to a $250 per admission deductible	60% of coverage; subject to a $250 per admission deductible	90% of coverage; subject to a $400 per admission deductible
• Well-newborn care	100% of coverage; not subject to deductible	Not covered	90% of coverage; not subject to deductible
Covered Services			
Outpatient Surgery— Hospital/Facility	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Emergency Care Treatment of an emergency medical condition or injury	90% of coverage after a $100 per visit co-payment; co-payment waived if admitted; subject to deductible	90% of coverage after a $100 per visit co-payment; co-payment waived if admitted; subject to deductible	90% of coverage after a $100 per visit co-payment; co-payment waived if admitted; subject to deductible
Outpatient Testing, Lab, etc.			
Laboratory; X-Rays; Diagnostic Tests; Injections, including Medications Covered Under Medical Benefits—for the Treatment of an Illness or Injury	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences*
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after $100 co-payment	Non-emergency use of the emergency room not covered.
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after $25 co-payment if billed as office visit	Kaiser Permanente – 90% of coverage; subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% for shots and serum after a $25 per visit co-payment	Kaiser Permanente – $5 for shots and $50 for a three-month supply of serum
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage not subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after a $100 per visit co-payment; co-payment waived if admitted	Non-emergency use of the emergency room not covered.
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	

Chart continued pg. 14

	PPO OPTION		INDEMNITY
	In-Network/Georgia	Out-of-Network	
Behavioral Health	*The Plan Pays:*		*The Plan Pays:*
Mental Health and Substance Abuse Inpatient Facility **NOTE:** All services require prior authorization.	90% of coverage; subject to deductible limited to 45 days combined per Plan Year	60% of coverage; subject to deductible limited to 45 days combined per Plan Year	90% of coverage; subject to deductible limited to 45 days combined per Plan Year
Partial Day Hospitalization and Intensive Outpatient **NOTE: Notification Required.**	90% of coverage; subject to deductible limited to 60 days combined per Plan Year	No benefit	90% of coverage; subject to deductible limited to 60 days combined per Plan Year
Professional Charges Inpatient	90% of coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year	60% of coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year	90% of coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year
Mental Health and Substance Abuse Outpatient Visits **NOTE: Notification Required.**	90% of coverage; subject to deductible, limited to 50 visits combined per Plan Year	60% of coverage; subject to deductible; limited to 25 visits combined per Plan Year	90% of coverage; subject to deductible; limited to 50 visits combined per Plan Year
Dental			
Dental and Oral Care **NOTE:** Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Temporomandibular Joint Syndrome (TMJ) **NOTE:** Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit. This does not apply to the HMO	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Vision			
	90% of coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	90% of coverage; not subject to deductible; limited to one eye exam every 24 months
Other Coverage			
Ambulance Services for Emergency Care **NOTE:** "Land or air ambulance" to nearest facility to treat the condition.	90% of coverage; subject to deductible	90% of coverage; subject to deductible	90% of coverage; subject to deductible

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences*
90% of coverage; subject to deductible limited to 30 days combined per Plan Year	60% of coverage; subject to deductible limited to 30 days combined per Plan Year	90% of coverage; not subject to deductible and limited to 30 days combined per Plan Year	Kaiser Permanente – 90% of coverage; subject to deductible and unlimited days for mental health; 30-day limit for substance abuse
90% of coverage; subject to deductible limited to 60 days combined per Plan Year	60% of coverage; subject to deductible limited to 30 days combined per Plan Year	Each HMO may or may not offer this benefit; contact the HMO for more information	
90% of coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year	60% of coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year	90% of coverage; not subject to deductible	Kaiser Permanente – 90% of coverage; subject to deductible
90% of coverage; subject to deductible limited to 50 visits combined per Plan Year	60% of coverage; subject to deductible limited to 25 visits combined per Plan Year	100% after $25 per visit co-payment; limited to 25 visits combined per Plan Year	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after applicable co-payment, if inpatient/ outpatient facility; subject to deductible	Kaiser Permanente – 50% coverage on first $1,000, if inpatient/ outpatient facility; subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after applicable co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/outpatient facility, 90% subject to deductible	Kaiser Permanente – 50% for non-surgical treatment; excludes appliances and orthodontic treatment; if inpatient/outpatient facility; 90% subject to deductible
90% of coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	Contact HMO directly for more information	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100%	Kaiser Permanente – 100% after a $50 per trip co-payment when medically necessary.

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	PPO OPTION		INDEMNITY
	In-Network/Georgia	Out-of-Network	
Other Coverage	*The Plan Pays:*		*The Plan Pays:*
Urgent Care Services	90% of coverage after a $45 per visit co-payment; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Home Healthcare Services **NOTE:** Prior approval required	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Skilled Nursing Facility Services **NOTE:** Prior approval required	90% of coverage; up to 45 days per Plan Year; subject to a $250 per admission deductible	Not covered	90% of coverage; up to 45 days per Plan Year; subject to a $400 per admission deductible @ contracted facility
Hospice Care **NOTE:** Prior approval required	100% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or Purchase	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services	90% of coverage; subject to deductible and $20 per visit co-payment up to 40 visits per Plan Year	60% of coverage; subject to deductible and $20 per visit co-payment up to 40 visits per Plan Year	90% of coverage; subject to deductible and $20 per visit co-payment up to 40 visits per Plan Year
Chiropractic Care **NOTE:** Coverage for up to a maximum of 20 visits per Plan Year	90% of coverage; after a $30 per visit co-payment; not subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Transplant Services **NOTE:** Prior approval required	90% of coverage; subject to deductible at contracted transplant facility	Not covered	90% of coverage; subject to deductible at contracted transplant facility
Pharmacy			
Generic Co-payment	$10	$10	$10
Preferred Brand Co-payment	$30	$30	$30
Non-Preferred Brand Co-payment	$100	$100	$100

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
The Plan Pays:		*The Plan Pays:*	*HMO Plan Differences*
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after $25 co-payment	BlueChoice – referral required. Kaiser Permanente – 100% after $30 co-payment
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage; up to 120 visits per Plan Year	
90% of coverage up to 45 days per Plan Year; subject to deductible	Not covered	90% of coverage; up to 45 days per Plan Year; subject to deductible	United Healthcare – 90% of coverage, up to 120 days per Plan Year; subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage; subject to deductible	CIGNA – 90% of coverage; subject to deductible; outpatient 100% not subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage when medically necessary	
90% of coverage up to 40 visits per Plan Year; subject to deductible	60% of coverage up to 40 visits per Plan Year; subject to deductible	100% of coverage after $25 per visit co-payment; up to 40 visits per Plan Year	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage after $25 co-payment per visit	
90% of coverage; subject to deductible at contracted transplant facility	Not covered	90% of coverage; subject to deductible	
80% of coverage; subject to deductible $10 min./$100 max.	Not covered	$10	Kaiser Permanente – Kaiser facility: $10 Eckerd Drugs: $16
80% of coverage; subject to deductible $10 min./$100 max.	Not covered	$25	Kaiser Permanente – Kaiser facility $25 Eckerd Drugs: $31
80% of coverage; subject to deductible $10 min./$100 max.	Not covered	$50	Kaiser Permanente – N/A

IMPORTANT PLAN CONSIDERATIONS

If you are covered under the PPO, Indemnity, High Deductible Health Plan or CCO option, for these options, you are required to obtain the necessary prior notification or prior approval for all inpatient admissions and certain covered services under the Plan. You should contact member services regarding notification requirements and verification of covered services.

PPO and Indemnity Progressive Drug Management Program (PDMP)

This program assists your doctor in finding the most appropriate drug for you. The first step is usually a proven, less expensive treatment known to be safe and effective. If the drug does not work for you, your doctor may progress to another drug. A prior authorization may be required as the next step in the program.

Note: If you should go to the pharmacy and are told that your prescription cannot be filled because it requires prior authorization, please have your doctor call Express Scripts with your clinical information.

Important PPO, Indemnity Considerations

See the Summary Plan Description and *Updaters* for coverage details, including limitations and exclusions.

- Some services may require prior approval before such services are covered. **Prior notification is the member's responsibility to obtain.** Also, some services may have limitations not contained in this summary.
- Charges from non-participating providers are subject to balance billing. These charges are the member's responsibility and do not count toward deductibles or out-of-pocket spending limits.
- Services covered under the PPO from in-network providers will apply to the in-network deductible and out-of-pocket limit.
- Services covered under the PPO from out-of-network providers apply to the out-of-network deductible and out-of-pocket limit.
- Co-payments do not apply toward deductibles or out-of-pocket limits unless otherwise noted.

High Deductible Health Plan Considerations

The HDHP covers the same services and supplies as the SHBP's PPO Option, and includes the same network of participating physicians and hospitals – here in Georgia and across the United States. The HDHP also reflects the importance of preventive care, with a $500 annual benefit with no deductible.

Deductibles:

- The deductible applies to everything except the first $500 in preventive care expenses. If you have family coverage, you must meet the family deductible before benefits are payable for any family member.
- With the HDHP, you pay coinsurance after the deductible for in-network office visits and prescription drugs.

Your Health Savings Account (HSA) Opportunity

An HSA is like a personal savings account for healthcare, except it's all tax-free. When you enroll in the HDHP, you may be eligible to open a HSA with an independent HSA administrator/custodian. You will need to contact a local bank or other financial organization to set-up your HSA Account.

You may open a HSA if you enroll in the HDHP and do not have other coverage – through your spouse's employer's plan, Medicare, Medicaid, a full unrestricted HCSA – or any other medical plan.

HSA Highlights	
What you can contribute each year	Up to HDHP deductible amount: • $1,100 if you have individual coverage • $2,200 if you have family coverage as long as you continue to be enrolled in the HDHP. If you are 55 or older, you may contribute additional dollars – up to $700/year – as "catch-up" contributions
How you contribute	Through deposits you make directly to the HSA administrator you select…either in a lump sum or in installments throughout the year. Payroll deductions may be available through your employer.

HSA Highlights *continued*	
What you can use your HSA to pay	Healthcare expenses (medical, dental, vision, over-the-counter medications) the IRS considers tax-deductible that aren't covered by any healthcare plan…see IRS Publication 502 at **www.irs.gov**.
How claims are paid	Varies based on HSA administrator, but generally you can pay expenses directly from your account (using a debit card or convenience checks), so there's no claim paperwork to submit
What happens at the end of the year	Unused money in your account carries forward and continues to earn interest
What happens if you don't enroll in the HDHP next year or leave your employer	You can no longer contribute to your HSA, but you keep the account and can continue to use the balance for eligible healthcare expenses

Points to Consider when selecting your HSA Administrator/Custodian

- **The organization's credentials:** As you look at an insurance company, a bank or other HSA custodian, check out its reputation for service, quality, licensing and financial stability.
- **Investment options:** How much interest will your HSA earn? Money market accounts typically earn 0.5% to 3.0% interest. Will you have a choice of investment options? Some HSA administrators require that your account balance reaches a certain threshold before you have investment choices.
- **Claim payment:** Many administrators offer a debit card that can be used at the doctor's office or pharmacy to pay your share of the cost of care, or even at an ATM to reimburse yourself for qualified expenses you have paid. Most offer checks, sometimes for an extra fee.
- **Account fees:** HSA administrators (typically) charge a set-up fee and a monthly maintenance fee. Sometimes there are additional transaction fees.

Important HMO Considerations

- Some services may require prior authorization by the HMO before such services are covered. Also, some services may have limitations not contained in this summary.
- Most HMOs require the selection of a primary care physician (PCP) to manage your care. Failure to specify a PCP could delay receipt of your ID card. However, in some instances the HMO assigns you a PCP located near your residence if a PCP is not specified. **Note: UnitedHealthcare does not require the selection of a PCP.**
- Most HMOs require you to obtain referrals to see most specialists. Failure to obtain a referral could result in denial of your claim. **Note: UnitedHealthcare does not require a referral for coverage of specialist services.**

NOTES APPLY TO ALL OPTIONS:

- **Preferred Drug Lists for SHBP members are subject to change. Prior to purchasing your medication(s), PPO and Indemnity members may view the drug lists at www.dch.georgia.gov or contact Express Scripts at 1-877-650-9342 or TDD 1-800-842-5754. HMO members may contact the HMO plan in which they are enrolled.**
- **Many drugs listed as non-preferred have a generic or a preferred brand name alternative. Preferred drug alternatives are therapeutically equivalent while being more cost effective.**
- **If the drug cost is less than the co-payment, you do not have to pay the co-payment but the actual cost of the drug.**
- **Co-payments for drugs covered under the SHBP will not be changed or overridden on an individual basis.**
- **The SHBP defines maintenance drugs as medications for specified chronic conditions. PPO, PPO CCO, Indemnity and Kaiser members may obtain up to a 90-day supply of maintenance prescription(s) at one time for three co-payments. BlueChoice, CIGNA, and UnitedHealthcare members may receive a 90-day supply of maintenance prescriptions for two co-payments. Your co-payments are based on supplies of up to 30 days as this is the industry standard. However, some drugs are limited to a standard other than the 30-day supply for one co-payment.**
- **Lifetime benefit maximums are combined totals among the PPO Options, Indemnity, HDHP Option and HMO Options.**
- **Annual dollar and visit limitations, deductibles and out-of-pocket spending limits are based on January 1, 2006 to December 31, 2006.**
- **Contact each plan directly for more details regarding covered services, exclusions and limitations.**

IF YOU ARE RETIRING…WHAT YOU NEED TO KNOW

The following information and "Important Notices about your Prescription Drug Coverage and Medicare" are provided to assist you with Retirement Planning.

! If you want to have health insurance under SHBP when you retire, you must enroll for coverage for you and any eligible dependents during the Open Enrollment period prior to your retirement.

Once retired, during the annual Retiree Option Change Period, you are allowed to change your Plan option only. You may add dependents only if you experience a qualifying event and request the change within 31 days.

1 SHBP will pay primary benefits for non-enrolled Medicare eligible retirees as well as retirees who are not entitled to Medicare because they did not participate in Social Security or pay Medicare taxes. The premiums for these primary payments will be increased the month in which the retiree (or dependent spouse) becomes 65 or becomes eligible for Medicare due to disability.

2 Effective January 1, 2006, the SHBP will implement a new Medicare policy. SHBP will calculate premiums and claims payment based upon Medicare enrollment for retirees over age 65 or those eligible for Medicare due to disability. As in the past, SHBP will coordinate benefits for members who are enrolled for Medicare Part A and/or B. Additionally, coordination will also begin for retirees who enroll in the Medicare Part D Prescription Drug Plan (PDP). Premiums will be reduced for each part of Medicare for which the retiree enrolls.

Additional Information Concerning Medicare Part D

Medicare Part D will offer a standard and enhanced prescription drug plan if you are eligible for Part A and/or enrolled in Part B, you are eligible for Part D. If you are considering enrolling in a Part D plan, SHBP suggests that you enroll in a standard plan. The standard plan and the coordination of benefits with SHBP should meet your coverage needs. Please note that certain medications have specific Quantity Level Limits and some require Prior Authorization. The SHBP will still apply these requirements and limits to your prescription drug coverage.

If you will be retiring and are considering enrolling in the Kaiser Medicare Advantage (MA) option, you must make your election on the Membership Worksheet and submit to SHBP. Kaiser will mail you a Senior Advantage application that you will need to complete. You should also check Medicare Part D on this application. By checking this box, you are agreeing to have Part D Prescription Drug Coverage administered by Kaiser.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

PPO, Indemnity, CIGNA, United Healthcare HMO, Kaiser Permanente, BlueChoice and TRICARE Supplement Plan Options

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and the new prescription drug coverage available soon for people with Medicare.

1 Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.

2 DCH has determined that the prescription drug coverage offered by the SHBP is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

3 Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 through December 31.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

Because your existing coverage with one of the following SHBP Options: PPO, Indemnity, CIGNA, United Healthcare HMO, Kaiser Permanente, BlueChoice, and TRICARE Supplement is on average at least as good as the standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

If you do decide to enroll in a Medicare prescription drug plan and drop your coverage with the SHBP, be aware that your next opportunity to enroll with the SHBP will be during the 2006 Open Enrollment for calendar year, January 1, 2007 through December 31, 2007, or if there is a qualifying event.

REMEMBER TO KEEP THIS NOTICE. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

You should also know that if you drop or lose your coverage with SHBP and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1 percent per month for every month after May 15, 2006, that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage…contact your Pharmacy Benefit Manager at the number on your identification card or call the State Health Benefit Plan at 404-651-6142 or 800-610-1863. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

More information about your options under Medicare prescription drug coverage…will be available in October 2005 in the "Medicare & You 2006" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit **www.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number).
- Call 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Please contact the Social Security Administration (SSA) at 1-800-772-1213 (TTY 1-800-325-0778) or visit their Web site at **www.socialsecurity.gov** for more information about this extra help.

IMPORTANT NOTICE ABOUT YOUR HDHP PRESCRIPTION DRUG COVERAGE AND MEDICARE

High Deductible Health Plan Option

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and new prescription drug coverage available soon for people with Medicare.

1 Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.

2 DCH has determined that the prescription drug coverage under the High Deductible Health Plan Option offered by the SHBP is, on average for all plan participants, NOT expected to pay as much as the standard Medicare prescription drug coverage will pay. This is important, because for most people, enrolling in Medicare prescription drug coverage before May 15, 2006, means you will get more assistance with drug costs.

3 You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll. Read this information carefully – it explains your options.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug coverage will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because the coverage you have with the State Health Benefit Plan is on average for all plan participants in the High Deductible Health Plan Option, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay, you might want to consider enrolling in a Medicare prescription drug plan. You can first join between November 15, 2005 and May 15, 2006. This is important, because if you do not get Medicare prescription drug coverage (or equivalent coverage) before May 15, 2006, you may have to pay a higher premium if you join later. You will pay that higher premium as long as you have Medicare prescription drug coverage.

If you don't enroll in Medicare prescription drug coverage by May 15, 2006, you may pay more. If you enroll after May 15, 2006, your monthly premium for a Medicare prescription drug plan could be much higher. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your premium will go up at least 1 percent per month for every month after May 15, 2006, that you did not have that coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19 percent higher than what most other people pay.

If you don't enroll in a Medicare prescription drug plan by May 15, 2006, you may also have to wait to enroll. Generally, after May 15, 2006, you can only join a Medicare prescription drug plan between November 15 and December 31 of any year. This may mean the number of months you have to wait for coverage will be longer, which could make your premium higher.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You need to make a decision. When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

For more information about this information or your current prescription drug coverage…contact your Pharmacy Benefit Manager at the number on your identification card or call the State Health Benefit Plan at 404-651-6142 or 1-800-610-1863. **NOTE:** You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…more detailed information about Medicare plans that offer prescription drug coverage will be available in October 2005 in the "Medicare & You 2006" handbook from Medicare you will receive in the mail. You may also be contacted directly by Medicare-approved prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit **www.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number).
- Call 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

DISCLAIMER: This material is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided in order to fully understand the provisions of the option chosen.

Georgia Department of
Community Health